MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01531

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Physicians Memorial
How long in hospital or institution? 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry Alexander Bivins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 22, 1906

8. AGE: Years	Months	Days	If less than one day
39	7	28	..... hrs. ..... min.

9. Birthplace: La Plata, Charles, Md.
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Restaurant & bar

FATHER
12. Name: Richard Bivins
13. Birthplace: La Plata, Md.

MOTHER
14. Maiden name: Eleanor Grasp
15. Birthplace: La Plata, Md.

16. Informant: Sarah Bivins
Address: La Plata, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-22-46 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: La Plata Md
18. Funeral director: Hewitt & Ryon
Address: Waldorf, Md

19. 2-20 (Date rec'd by registrar) 1946 Julia A Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Febr. 19, 1946, at 6:40 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 16, 1946, to Febr. 19, 1946
and that I last saw him alive on Febr. 18, 1946

Immediate cause of death	DURATION
Pulmonary embolism	minutes
Due to: Subacute bacterial endocarditis	36-37 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: James L. MacKavanagh, M.D.
M. D. or other
Address: La Plata, Md. Date signed 2-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01532

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:
County: Charles
City or town: Potomac Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles.
City or town: Potomac Heights.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Chiles Bowie

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah E. Bowie
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): March 14, 1878.

8. AGE:

Years	Months	Days	If less than one day
67	10	27	hrs. min.

9. Birthplace: Cross Roads - Anne Co., Md.
(Town, county, and state)
10. Usual occupation: Powder factory attendant Retired
11. Industry or business:

FATHER
12. Name: Edward Bowie
13. Birthplace: Unknown

MOTHER
14. Maiden name: Bettie Posey
15. Birthplace: Nanjemoy, Md.

16. Informant: Mrs. Sarah Bowie
Address: Potomac Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 13 1946 (month) (day) (year)
Cemetery or crematory: Park Hill -
Location: Marlboro, Md.
18. Funeral director: Hunt & Ryon
Address: Waldorf Md.

19. 2/13/1946 (Date rec'd by registrar) Mary Swarthwood Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 1946 at 1:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Feb. 10 1946
and that I last saw h... alive on Feb. 9 1946

Immediate cause of death	DURATION
Diabetes Mellitus	
Due to	
Due to	
Other conditions: Cardiac Failure; Ascites	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Bickwell M.D.
M. D. or other
Address: Marlboro Md Date signed: Feb. 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01533

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: Dentsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Dentsville (If ontside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) Il veteran, name war —

3. (a) FULL NAME: Florence W. Cooksey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 1874

8. AGE: Years: 71 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Dentsville, Charles, Md. (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: own home

FATHER 12. Name: M. A. Cooksey

13. Birthplace: Chas. Co. Md.

MOTHER 14. Maiden name: Sarah E. Hancock

15. Birthplace: Chas. co. md.

16. Informant: J. B. Cooksey

Address: Dentsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/11/46 (month) (day) (year)

Cemetery or crematory: Dentsville M. E.

Location: Dentsville, Md

16. Funeral director: Hewett & Myers

Address: Waldorf, Md

19. 2-10 (Date rec'd by registrar) 19 46 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9, 1946 at 6 00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1935, to Feb. 9, 1946 and that I last saw h..m alive on Feb. 8, 1946

Immediate cause of death	DURATION
Coronary thrombosis	36 hrs.
Due to: Coronary artery disease	2-3 yrs.
Due to: Generalized arteriosclerosis	8-9 yrs.
Other conditions: Chronic cholecystitis	15 yrs.
Senile dementia	3-4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James E. MacKaverough, M.D. M. D. or other

Address: La Plata, Md. Date signed 2-9-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

01534

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles.

City or town: Chicamuxen.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Chicamuxen. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ella Mae Ennis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 4. 1910

8. AGE:

Years	Months	Days	If less than one day
35	6	2	hrs. min.

9. Birthplace: Chicamuxen

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: James Ennis

FATHER 13. Birthplace: Fairfax County, Va

MOTHER 14. Maiden name: India Hoff

MOTHER 15. Birthplace: Chicamuxen

16. Informant: India Ennis

Address: Chicamuxen

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 10, 1946 (month) (day) (year)

Cemetery or crematory: Alexandria Methodist

Location: Chicamuxen

18. Funeral director: Hunt & Cyon

Address: Waldorf, Md.

19. 2-8 1946 (Date rec'd by registrar) Julia H. Lacey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 6 1946, at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to Feb. 6 1946, and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	1 day
Due to	
Due to	
Other conditions: Obesity	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Luther G. Susa M.D. M. D. or other

Address: Indian Head, Md. Date signed 2/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01535

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:
County Charles
City or town Ironsides
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one month
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Charles
City or town Ironsides
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION) —
2.(a) If veteran, name war

3.(a) FULL NAME Albert Franklin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) March 15, 1913

8. AGE:	Years	Months	Days	If less than one day
	32	11	12	...... hrs. ...... min.

9. Birthplace Nanjemoy Charles, Md. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name John Franklin
13. Birthplace Chas. Co., Md.

MOTHER
14. Maiden name Sarah Starks
15. Birthplace Nanjemoy, Md.

16. Informant Tiny Johnson (aunt)
Address Ironsides, Md.

17. Burial Date thereof 2/28/46
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Oak Grove
Location Grayton, Md
19. Funeral director Hewitt & Ryon
Address Waldorf, Md

19. 2-27 1946 Mary Southerland Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Febr. 27, 1946, at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased [redacted] on Febr. 27, 1946, to ...... 19...
and that I ~~last~~ saw him [redacted] on Febr. 27, 1946

Immediate cause of death Natural causes — app. chronic wasting disease — [redacted] exact cause unknown — DURATION: acutely, 2 days
Due to Pulmonary tuberculosis; two years.
Other conditions Tuberculous osteomyelitis.
(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ...... Date of ......
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ...... Injured at work?

23. SIGNATURE James L. MacKavanagh, M.D. M. D. or other
Address La Plata, Md. Date signed 2-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Hyg)

01536

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: La Plata, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Minnie Elizabeth Garner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband ~~or wife~~: Robert S. Garner
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Aug. 31, 1865

8. AGE: Years: 80 | Months: 5 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: La Plata, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel M. Padgett
13. Birthplace: Chas. Co. Md

MOTHER
14. Maiden name: Elizabeth Rose Mourse
15. Birthplace: Chas. Co. Md.

16. Informant: Robert M. Garner
Address: La Plata, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/12/46 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: La Plata, Md.

18. Funeral director: Hewitt & Rymm
Address: Waldorf, Md.

19. 2-11 19 46 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-10 19 46, at 8 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-11 19 45, to 2-10 19 46; and that I last saw h alive on 2-10 19 46

Immediate cause of death	DURATION
Coronary Thrombosis	2.10.46
Due to: Gen. Arterio Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: La Plata, Md. Date signed 2-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

01537

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: Wicomico Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Wicomico Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ho Tomkinsville Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Daniel R Geddes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife: Bess M Geddes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 26-1888

8. AGE: Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace: Rochester New York
(Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Household Effects

FATHER
12. Name: David Geddes
13. Birthplace: Scotland

MOTHER
14. Maiden name: Agnes Orr
15. Birthplace: Scotland

16. Informant: Mrs Bess M. Geddes
Address: Wicomico

17. Burial, cremation, or removal. Which?: Removal
Date thereof: Feb. 13 1946 (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.

18. Funeral director: W.W. Chambers Co.
Address: 1400 Chapin St. Wash., D.C.

19. 2-13 1946 (Date rec'd by registrar)
Julian H Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13, 1946, at 7 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-13 1946, to 2-13 1946
and that I last saw h... alive on Feb. 13 1946

Immediate cause of death	DURATION
Coronary Thrombosis	2-11-46
Due to: Sen. Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: O Kedellen M.D.
M. D. or other
Address: LaPlata Md. Date signed: 7-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

01540

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Wicomico

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Barbara Ann Hicks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 13, 1941

8. AGE:

Years	Months	Days	If less than one day
4	11	7	hrs. min.

9. Birthplace: Wicomico Charles, Md. (Town, county, and state)

10. Usual occupation: Child

11. Industry or business:

FATHER — 12. Name: John Bowman

13. Birthplace: St. Mary's Co, Md

MOTHER — 14. Maiden name: Nancy Hicks

15. Birthplace: Charles Co Md

16. Informant: Nancy Hicks

Address: Wicomico

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/21/46 (month) (day) (year)

Cemetery or crematory: Trinity

Location: New Port Md.

18. Funeral director: Hewitt & Ryon

Address: Waldorf, Md

19. 2-21 (Date rec'd by registrar) 19 46 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20, 1946, at 7:21 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Jan. 1, 1946, to Feb. 20, 1946

and that I last saw h[er] alive on Feb. 20, 1946

Immediate cause of death	DURATION
Severe secondary Anemia	3-4 mos.
Due to CHRONIC GLOMERULONEPHRITIS ?	
Due to	
Other conditions ASCARIS INFESTATIONS	?

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James L. MacKaye M.D. M.D. or other

Address: La Plata, Md. Date signed: 2-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01538

Reg. Dist. No. 165 104

1. PLACE OF DEATH:
County: Charles
City or town: Mt. Victoria, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Mt. Victoria
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: X

3.(a) FULL NAME: Major William Henry Lloyd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife: Edith Butler Lloyd
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 16, 1877

8. AGE: Years	Months	Days	If less than one day
68	7	28	____ hrs. ____ min.

9. Birthplace: Germantown, Md. (Town, county, and state)
10. Usual occupation: Retired, U.S. army.
11. Industry or business
FATHER 12. Name: Wilson Lloyd.
13. Birthplace: Philadelphia, Pa.
MOTHER 14. Maiden name: Sarah McAleister
15. Birthplace: McAllistsville, Pa.
16. Informant: Mrs Edith Butler Lloyd
Address: Mt. Victoria, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/46 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: Hulett & Ryon
Address: Macdon, Md.
19. 2-15-46 (Date rec'd by registrar) [redacted] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-14 1946, at 11 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-13 1946, to 2-14 1946
and that I last saw him alive on 2-14 1946.

Immediate cause of death	DURATION
Coronary Thrombosis	2-13-46
Due to: Hypertensive Heart	
Due to: Fibrosis and Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [redacted] M.D. (M.D. or other)
Address: La Plata, Md. Date signed 2-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-L)

CERTIFICATE OF DEATH

★ 01539

Reg. Diat. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: La Plata, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Physicians' Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md. County: Charles

City or town: Dancaster, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Morgan Laurence Monroe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 6, 1863

8. AGE:

Years	Months	Days	If less than one day
82	9	4	..... hrs. ..... min.

9. Birthplace Fredericksburg Va. (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

FATHER — 12. Name William Monroe

FATHER — 13. Birthplace Va.

MOTHER — 14. Maiden name Mary ?

MOTHER — 15. Birthplace Va.

16. Informant Laurence Monroe

Address Dancaster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 13/46 (month) (day) (year)

Cemetery or crematory Durham

Location Ironsides, Md

18. Funeral director Truitt & Ryon

Address Waldorf, Md.

19. 2-11 1946 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... 2-10 ..... 1946 at 9 16 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-8 1946, to 2-10 1946

and that I last saw him alive on 2-10 1946

Immediate cause of death	DURATION
Carcinoma of Rectum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place? (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Hollen M.D. M. D. or other

Address La Plata Md Date signed 2-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

01541

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (13)

County Charles Registration Dist. No. 103

Village or City Dentsville Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME John M. Neal If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M.	Col.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jane Neal.

6. DATE OF BIRTH (month, day, and year) - Dont Know 1888

7. AGE	Yeers	Months	Deys	If LESS than 1 day, hrs. or min.
About	58 ?			

OCCUPATION

8. Trade, profession, or particuler kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer.

9. Industry or business in which work was done, es SILK MILL, SAW MILL, BANK, etc.

10. Dete deceased lest worked at this occupetion (month end year)

11. Total time (years) spent in this occupetion

12. BIRTHPLACE (city or town) Charles Co. (State or country) Md.

FATHER

13. NAME Thomas Neal.

14. BIRTHPLACE (city or town) Charles Co (State or country) Md

MOTHER

15. MAIDEN NAME Dont Know.

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Thomas Neal (Address) Dentsville Md

18. BURIAL, CREMATION, OR REMOVAL Place Neal Path Date Feb 25th, 1946

19. UNDERTAKER Mont Hunt & Ryan (Address) Waldorf Md.

20. FILED 2-27, 1946 J. B. Dippert Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb (Month) 23 (Dey), 1946 (Yeer)

22. I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1946, to Jan 15th, 1946

I lest saw h-- elive on Jan 15th, 1946; death is seid to heve occurred on the date steted above, at 6 A.M.

The **PRINCIPAL CAUSE OF DEATH** and related ceuses of importance were es follows:

	Date of onset
Endocarditis	Dont Know

Other **Contributory Causes** of importance:

Pul. Tuberculosis

Neme of operetion Date of

Whet test confirmed diegnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in elso the following:

Accident, suicide, or homicide? Dete of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Wes diseese or injury in eny wey releted to occupetion of deceesed?

If so, specify

(Signed) Levin J. Washington M. D.

(Address)

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01542

Reg. Diat. No. 105

1. PLACE OF DEATH:

County Charles

City or town Waldorf Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles

City or town Pewaldon

(If outside city or town limits, write RURAL and give nearest town)

Street No. Berry Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Laurence A. O'Dea

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife Edith L. O'Dea

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 22, 1870

8. AGE: Years 75 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace New York, N.Y. (Town, county, and state)

10. Usual occupation Retired Soldier

11. Industry or business

FATHER 12. Name Laurence O'Dea

13. Birthplace New York

MOTHER 14. Maiden name Mary Quirk

15. Birthplace Unknown

16. Informant Edna Lloyd

Address 203 Cromwell Terrace N.E.

17. Burial (Burial, cremation, or removal, which?) Date thereof Feb 22 1946 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington D.C.

18. Funeral director Albert F. Ashe

Address 641 H. St. N.E.

19. 2-19 1946 (Date rec'd by registrar) M.C. Mott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to 2-19 1946 and that I last saw h... alive on 2-19 1946

Immediate cause of death Myocardial Degeneration

Due to Cardio-vas- Renal Disease

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

DURATION
1 year

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. P. Weber, M.D. M. D. or other

Address Waldorf, Md Date signed 2-19 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-P)

01543

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: Bel Alton

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or towo: Bel Alton

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Francis Claude Rice

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

B.(b) Name of husband or wife: Catherine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 22 - 1886

8. AGE: Years	Months	Days	If less than one day
59	2	13	..... hrs. ..... min.

9. Birthplace: Charles Co Md

(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business

FATHER 12. Name: Thomas Rice

FATHER 13. Birthplace: Charles Co Md

MOTHER 14. Maiden name: Elizabeth Farmer

MOTHER 15. Birthplace: Charles Co Md

16. Informant: Catherine Rice

Address: Bealton md

17. 2-9-46 Burial (Burial, cremation, or removal. Which?) Date thereof 2-9-46 (month) (day) (year)

Cemetery or crematory: St Ignatius

Location: Bealton Md

18. Funeral director: Hunt & Ryon

Address: Waldorf Md

19. 2-7 1946 (Date rec'd by registrar) Julia H Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5, 1946 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from October 1946, to Feb. 5. 1946

and that I last saw h. alive on February 5, 1946

Immediate cause of death	DURATION
Uremic coma and heart failure	8 hrs.
Due to: Chronic diffuse glomerulonephritis	Symptomatic 4 months
Due to:	
Other conditions: Asthmatic bronchitis	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James L. Mackenzie, M.D. M. D. or other

Address: La Plata, Md Date signed 2-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01544

Reg. Dist. No. 100

1. PLACE OF DEATH

County: Charles

City or town: LaPlata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Pres. Mem. Hosp

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Chas

City or town: Ironsides Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ernest Stinnett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Jessie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-25-96

8. AGE:

Years	Months	Days	If less than one day
49	10	10	..... hrs. ..... min.

9. Birthplace: Knoxville Tenn. (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business

FATHER

12. Name: Charles D. Stinnett

13. Birthplace: Knoxville Tenn

MOTHER

14. Maiden name: Mary Louella Mathews

15. Birthplace: Knoxville Tenn

16. Informant: Katherine Stinnett

Address: Ironsides Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-7-46 (month) (day) (year)

Cemetery or crematory: ~~Chapman Knoxville~~ Tenn

Location

18. Funeral director: Hamilton & Ryon

Address: Waldorf Md

19. 2-6 (Date rec'd by registrar) 19 46 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-4 19 46, at 12 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-30 19 46 to 2-4 19 46

and that I last saw h im alive on 2-4 19 46

Immediate cause of death	DURATION
Coronary Thrombosis	1-30-46
Due to, or as a consequence of: Arteriosclerotic Heart Disease	
Due to, or as a consequence of:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: E Heller M. D

M. D. or other

Address: LaPlata Md Date signed 2-4-46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01545

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:
County: Charles
City or town: LaPlata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days.
Hospital, institution, or street address where death occurred: Chas. Gen. Hosp.
How long in hospital or institution? 14 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Charles
City or town: Westwood md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lucille Mudd Summers

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: J. Francis Summers
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 1st 1900

8. AGE: Years	Months	Days	If less than one day
45	6	12	hrs. min.

9. Birthplace: Race Maedow md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Samuel A. Mudd
13. Birthplace: Bryantown md
MOTHER 14. Maiden name: Louise Burch
15. Birthplace: Bryantown md
16. Informant: J. Francis Summers
Address: Westwood md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-15-46 (month) (day) (year)
Cemetery or crematory: St Peters
Location: Maedow md
18. Funeral director: Hewitt & Dyson
Address: Maedow md
19. 2-14 1946 (Date rec'd by registrar) M L Mudd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 13 1946, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-24-46 to 2-13 1946
and that I last saw her alive on Feb 13 1946

	DURATION
Immediate cause of death: Congestive Heart Failure	1-31-46
Due to: Rheumatic Heart Disease	1936
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followlog:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Allen H.D. M. D. or other
Address: LaPlata, Md. Date signed 2-13-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (86)

CERTIFICATE OF DEATH

01546

Reg. Diat. No. 120

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lawrence Leon Thomas

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 23, 1946

8. AGE: Years | Months | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: LaPlata Charles Co.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: George Thomas (deceased)
13. Birthplace: Chas Co., Md.

MOTHER
14. Maiden name: Inez ~~Thomas~~ Brown
15. Birthplace: Chas. Co, Md.

16. Informant: Sarah Johnson
Address: LaPlata, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-1-46 (month) (day) (year)
Cemetery or crematory: Sacred Home
Location: LaPlata, Md.

16. Funeral director: Sarah Johnson, (1st Cousin)
Address: LaPlata, Md

19. May 1, 1946 (Date rec'd by registrar) Julia A. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-28 1946 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Unknown Prob Dehydration	
History: Baby failed to eat	Fever
Due to: Sister birth Had	
convulsion 8:30 A.M. 5-28-46	
Due to: Patient dead on arrival 9 A.M	5-28-46
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. Edelen M.D.
M. D. or other
Address: LaPlata, Md. Date signed 5-28-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15